| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 157078 | A. BUILDING _____ B. WING _____ | 09/20/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **PULASKI MEMORIAL HOME HEALTH & HOSPICE** | **616 E 13TH ST PO BOX 279 WINAMAC, IN 46996** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| G 000 | INITIAL COMMENTS<br><br>This was a federal home health recertification survey.<br><br>Survey dates: 9/17/12 - 9/20/12<br><br>Facility #: 5285<br><br>Medicaid #: 100263320A<br><br>Surveyor: Ingrid Miller RN, PHNS<br><br>Skilled unduplicated census: 224<br><br>Pulaski Memorial Home Health and Hospice is in compliance with the Conditions of Participation 42 CFR Part 484.<br><br>Quality Review: Joyce Elder, MSN, BSN, RN<br>September 25, 2012 | G 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.